Inclusion Handouts

1. Activity Registration Form
2. Assessment Team Summary
3. Supplemental Information Tracking Form
4. Participant Supplemental Information Form
5. Participant Allergy Information Form
6. Participant Asthma Information Form
7. Participant Seizure Information Form
8. Participant Diabetes Information Form
9. Physician Report and Clearance
10. Authorization for Release of Information

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

ACTIVITY REGISTRATION FORM

FOR OFFICE USE [S]
Verified By _____
Date _____

1) **BOTH SIDES** of this form must be completed and signed for each participant prior to participating in the activity.
2) Mail form with payment to Parks and Recreation Department, P.O. Box 1990, Santa Barbara, CA 93102 or fax form with payment to 805-897-2520 or drop off form with payment to Cabrillo Bathhouse, 1118 E. Cabrillo Blvd, (Oceanside) or the Carrillo Recreation Center, 100 E. Carrillo St. (Downtown)

PARTICIPANT'S LAST NAME FIRST NAME

Custodial Parent / Legal Guardian (if participant is a minor) _____

Address _____ City _____ Zip _____

Email Address _____ Participant Birth Date ____/____/____ ❑ Male ❑ Female

Cell Phone: _____ Home phone: _____ Work phone: _____

❑ Check this box if you do not wish to receive email announcements from Parks and Recreation

ACTIVITY AND PAYMENT INFORMATION

Complete when registering in-person, by mail, fax or online. Enter the activity sessions for which you are registering the above participant.

Activity Code #	Activity Name & Session	Start Date	Fee

Payment Method: ❑Cash (do not mail) ❑Check to City of Santa Barbara ❑Registered & paid online **TOTAL FEES:**

❑ Credit Card Credit card payments may only be accepted online, by phone or in person. Do not write credit card numbers on this form.

CODE OF CONDUCT FOR ALL PARTICIPANTS: By submitting this application, you, for yourself or on behalf of your minor child, agree to abide by the policies and conditions of the City of Santa Barbara Parks and Recreation Department "Code of Conduct." (For the complete Code of Conduct policy, see our website www.sbparksandrecreation.com on the "About Parks & Recreation" page or the current Parks and Recreation Activity Guide.)

RELEASE AGREEMENT FOR ALL PARTICIPANTS: CITY OF SANTA BARBARA RELEASE AGREEMENT IN CONSIDERATION OF BEING PERMITTED TO PARTICIPATE OR USE OF ANY CITY FACILITIES IN CONNECTION WITH THIS ACTIVITY, THE UNDERSIGNED AGREES TO THE FOLLOWING:

1. THE UNDERSIGNED HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE THE CITY OF SANTA BARBARA, ITS EMPLOYEES, OFFICERS AND AGENTS (hereinafter referred to as "releasees") from all liability to the undersigned, his or her personal representatives, assigns, heirs, and next of kin for any loss, damage, or claim therefore on account of injury to the person or property of the undersigned, whether caused by any negligent act or omission of the releasees or otherwise while the undersigned is participating in a City activity or using any City facilities in connection with the activity.

2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND HOLD HARMLESS releasees from all liability, claims, demands, causes of action, charges, expenses, and attorney fees (including attorney fees to establish the releasees right to indemnity or incurred on appeal) resulting from involvement in this activity whether caused by any negligent act or omission of the releasees or otherwise.

3. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR RISK OF BODILY INJURY, DEATH, OR PROPERTY DAMAGE while upon City property or participating in the activity or using any City facilities and equipment whether caused by any negligent act or omission of releasees or otherwise. The undersigned expressly agrees that the foregoing release and waiver, indemnity agreement and assumption of risk are intended to be as broad and inclusive as permitted by California law and that if any portion thereof be held invalid, notwithstanding, the balance shall continue in full legal force and effect.

I ACKNOWLEDGE THAT I HAVE READ THE FOREGOING and that I am aware of the legal consequences of this agreement, including that it prevents me from suing the City or its employees, agents, or officers if I am injured or damaged for any reason as a result of participation in this activity. I further acknowledge that no oral representations, statements or inducements have been made.

IF THE PARTICIPANT IS A MINOR, his or her custodial parent or legal guardian must read and execute this agreement. I hereby warrant that I am the custodial parent or legal guardian of ✓_____ (PRINT PARTICIPANT'S FULL NAME) who is a minor, on my own and said minor's behalf to the terms and conditions of the foregoing agreement.

✓ Participant or Parent/Guardian (print) _____ Signature _____ Date _____

EMERGENCY CONTACT	Relationship	Home Phone	Work Phone	Cell Phone/Pager
1.				
2.				
3.				

It is the responsibility of the participant to disclose all relevant information regarding the participant's health and special needs. Additional information and/or a physician's clearance may be required for participants with special needs or medical conditions. Information will be kept confidential and used only to determine appropriate assistance.

HEALTH & SPECIAL NEEDS	YES	NO	If yes, explain and list current medications
ADD, ADHD	❑	❑	
Allergies	❑	❑	To what? ❑Hives/rash ❑Breathing difficulty ❑Epi-pen ❑Benadryl
Asthma	❑	❑	Requires medication/inhaler ❑Yes ❑No When? ❑Daily ❑As needed ❑With exercise
Communicable diseases	❑	❑	
Diabetes	❑	❑	❑ Type I ❑ Type II ❑ Is independent in diabetes self care ❑ Needs daily assistance
Diet or activity restrictions	❑	❑	
Medications	❑	❑	
Seizure Disorder	❑	❑	Date of last seizure: / / Seizure type:
Other conditions/disabilities	❑	❑	
Wheelchair user	❑	❑	Transfers: ❑ Independently ❑ Partial Assistance ❑ Full Assistance
Requesting assessment for disability (Inclusion) support	❑	❑	Contact 564-5421 for more information on our Inclusion program.

PHOTOGRAPH RELEASE FOR ALL PARTICIPANTS: The Parks and Recreation Department may take and use photos of participants for publicity purposes. Photos of participants are used in the City's activity guide and other media publications. I hereby grant the City of Santa Barbara permission to use my likeness, name, voice and words in any broadcast, telecast or print media account of this event or activity free of charge. **INITIAL HERE**_____

INFORMATION BELOW FOR PARTICIPANTS UNDER 18 YEARS OLD

School_____ Grade Sept/2013 _____

Others authorized to pick up the participant _____

PERMISSION TO AUTHORIZE TREATMENT FOR MINORS: In the event of emergency injury or illness while the participant is attending the recreation activity, I hereby authorize the Parks and Recreation Department to consent to medical treatment on behalf of my child. The undersigned, as parent or legal guardian of the child identified on this form, hereby authorizes the Parks and Recreation Department and its adult officers, employees and agents into whose care the registered child has been entrusted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advice of a licensed physician or surgeon. This authorization is given pursuant to the provisions of section 6910 of the Family Code of California. It is understood that if time and circumstances reasonably permit, the Parks and Recreation Department will endeavor, but is not required, to communicate with the parent or guardian prior to consenting to such treatment. The undersigned further agrees to RELEASE, WAIVE, DISCHARGE AND COVENANTS NOT TO SUE the City of Santa Barbara, its employees, officers and agents on behalf of the undersigned, the registered minor and their personal representatives, assigns, heirs, and next of kin for any loss, damage, or claim therefore on account of any injury to the minor associated with any medical care performed or provided with consent given pursuant to this authorization. This authorization to consent to treatment of the minor identified above is given to the Parks and Recreation Department in conjunction with any activity or event in which the minor's care is entrusted to the Parks and Recreation Department. **INITIAL HERE**_____

PERMISSION FOR FIELD TRIPS FOR MINORS: Some recreation activities include field trips to parks or public sites. Staff and participants arrive at their destination by either walking or riding on public buses, trolleys or other City-approved vehicles. I hereby consent to the staff of Parks and Recreation Department taking my child on field trips during the recreation activity. **INITIAL HERE**_____

PARTICIPANT SWIM ABILITY ASSESSMENT FOR MINORS: The Recreation Program may include aquatic activities at a pool, beach or other location with water. Please check the box below with the description that most closely fits the participant.

❑	Type I	Does not know how to swim or is uncomfortable or nervous around water. Cannot put their face in the water, hold their breath, right themselves or float
❑	Type II	Can hold their breath, fully submerge their head under water, right themselves, float unsupported for five (5) seconds, flutter kick and to turn over from front and back. Is uncomfortable in water over their head and is unable to propel themselves beyond ten (10) yards.
❑	Type III	Comfortable in deep water, can demonstrate basic swimming stroke techniques with controlled breathing, can propel themselves twenty five (25) meters and tread water for two minutes.
❑	Type IV	Comfortable in deep water, can demonstrate advanced swimming stroke techniques with controlled breathing, can continuously propel themselves for a minimum of 100 meters, tread water for four (4) minutes and swim fifteen (15) meters under water

City of Santa Barbara Parks and Recreation Department
Adapted Recreation Program

ASSESSMENT TEAM SUMMARY

PARTICIPANT'S NAME_____ **Program**_____

Reviewed, initialed and dated:

- ☐ Inclusion Coordinator _____
- ☐ Camp Director _____
- ☐ Nurse _____
- ☐ Supervisor _____
- ☐ Parent / Guardian _____
- ☐ Inclusion Staff _____
- ☐ Other_____
- ☐ Other_____

Assigned General Supervision Level _____

Alternate Supervision Level for Specific Activities:

Activity _____ Level _____

GENERAL SUPERVISION PROVIDED IN THE CAMP SETTING -

Each camp shall maintain the designated staff to camper ratio throughout the day. For purposes of calculating the ratio, staff shall include the Camp Director and camp counselors. Personal assistants are not counted when calculating the ratio. Staff is to maintain visual and audio contact with campers, exceptions may include unaccompanied bathroom or locker room visits (where appropriate). Additional supervision may be required as determined through the camper assessment.

Level 0 = Not appropriate for camp or activity
Camp or activity is not appropriate for the individual. Necessary accommodation(s) would require a fundamental alteration of the activity or would cause an undue financial or administrative burden.

Level 1 = One on one, requires constant supervision or assistance
Camper may be a runner, wanderer, lack impulse control, or exhibit other behavior that requires one-on-one supervision, or camper may require extensive physical assistance due to physical limitations. Supervision: Camper requires one-on-one supervision or assistance from an assigned individual at all times during the activity. The camper may participate in a group setting, but staff or an assistant shall be no more than five feet (5') from the camper at all times during the activity. If an activity or the camper's limitations so require, additional supervision duties may be required; specific conditions shall be indicated in this assessment.

Level 2 = Moderate impairment - visual supervision required
Camper has moderate physical and/or developmental impairment, but camper can respond to gestures and/or verbal prompting. Camper may have paralysis and/or may spend most of their in time in a wheelchair, but does not require constant attention of staff or an assistant. When out of sight of supervision, camper may demonstrate impulsive behavior or attention difficulties. Supervision: Staff or an assistant must be within visual contact with camper at all times during the activity. If the primary staff or assistant cannot maintain visual contact, the primary staff or assistant must secure assistance from another assistant or staff member. Additional assistance may be necessary for mobility and toileting.

Level 3 = Limited impairment - direct supervision not required

Camper has limited physical and/or developmental impairment. Camper is able to walk without assistance or use a motor wheelchair and has the ability to propel and transfer from the wheelchair without assistance. Camper has the ability to sit quietly and maintain focus for at least 30 minutes; converse and process information; and can recognize and avoid obvious safety hazards. Supervision: Staff or an assistant must be close enough to respond immediately to an emergency or a need. A staff member or assistant shall check on the camper at least once every fifteen (15) minutes. A staff member or assistant shall be within hearing distance at all times during the activity in order to respond to calls or verbalizations.

Level 4 = Same supervision given as other campers at Host Program
Camper indicated "special needs" on the registration form. The Assessment Team determined the camper does not require intervention beyond informing staff of the special need. Supervision: No extra supervision or assistance is required beyond what is provided to other program participants.

Distribution and date:

☐ Inclusion counselor _____ ☐ Camp Director_____ ☐ File _____

Participant's name _____

Summary of Physician Clearance, Conversations with parents, C.I.F. & other information gathered through the registration process. Parent supplemental Information form is to be attached to complete the information collected.

DESCRIPTION OF SPECIAL NEEDS
COMMUNICATION
BEHAVIOR
PERSONAL ASSISTANCE
HEALTH CONCERNS
PHYSICAL DISABILITIES
SEIZURES
SWIM ASSESMENT
IS PHYSICAN REPORT AND CLEARANCE REQUESTED? YES_____ NO____ **If yes, date received_____**

Distribution and date:

☐ Inclusion counselor_____ ☐ Camp Director_____ ☐ File _____

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Tracking Hours _____

ADAPTED PROGRAMS
SUPPLEMENTAL INFORMATION TRACKING FORM

Participant_____ Age_____

Program(s) Attending _____ _____

_____ _____

_____ _____

Supplemental Forms	Required	Date mailed or down-loaded*	Date received	Date sent to host Program	Comments
Registration Form					
ADD/ADHD	❑ Yes ❑ No				
Allergies	❑ Yes ❑ No				
Asthma	❑ Yes ❑ No				
Authorization for Release of Information	❑ Yes ❑ No				
Diabetes	❑ Yes ❑ No				
Physician Clearance	❑ Yes ❑ No				
Seizure	❑ Yes ❑ No				
Supplemental Info	❑ Yes ❑ No				

* Write the date and "online" if the participant/parent said they will download the forms from the Internet.

Comments / Notes: _____

_____

_____

_____

_____

PARTICIPANT SUPPLEMENTAL INFORMATION FORM

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participant _____

Date _____

The registration information submitted for the above participant indicated there are medications, disabilities, or special information we should know about. We would appreciate your cooperation in answering the following questions to better understand the participant's special needs. If more space is needed, feel free to provide an additional attachment or submit all information on a separate sheet of paper. It is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian to disclose all relevant information regarding the participant's health and special needs.

Describe the specific disability or medical condition(s) of the participant and its effect on him or her.

COMMUNICATION

Describe the communication skills of the participant. Does he or she have difficulty communicating? If so, how does he or she react when frustrated due to inability to communicate with teacher, staff and peers?

BEHAVIOR

Does the participant have any behavior challenges of which staff should be aware such as: lacks impulse control, tends to wander off, is unaware of danger, can be physically aggressive, etc.? If the participant becomes oppositional, what usually triggers it and what is the best intervention?

PERSONAL ASSISTANCE
Does the participant require any special personal assistance for example eating, toileting, dressing, etc.?

HEALTH CONCERNS
Expand on any health issues or concerns of the participant such as: surgeries, diabetes, asthma, respiratory distress, heart difficulties, diseases, allergies, open wounds, etc.

PHYSICAL DISABILITIES
Does the participant have a physical disability (mobility, visual or hearing impairment)? If yes, will the participant be using any assisted device such as a wheelchair, stroller, walker, hearing aid etc.?

OTHER INFORMATION
Indicate any other information you would like to share about the participant. This may include the participant's most and least favorite activities.

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ **Signature** _____ **Print Full Name** _____ **Date** _____

PARTICIPANT ALLERGY INFORMATION FORM

CITY OF SANTA BARBARA
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Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participant _____

Date _____

The registration information submitted for the above participant indicated the participant has an allergy to _____. We would appreciate your cooperation in answering the following questions to better understand if there are any medical needs.

Please list below the participant's allergies, their severity and, describe the symptoms for each allergy such as difficulty breathing, swelling, hives, or other symptoms. It is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian to disclose all relevant information regarding the participant's health and special needs.

Allergy	Mild	Moderate	Severe	Symptoms
❑ Bee Stings	❑	❑	❑	_____
❑ Food	❑	❑	❑	_____
❑ Nuts	❑	❑	❑	_____
❑ Fish	❑	❑	❑	_____
❑ Other _____	❑	❑	❑	_____
❑ Dust	❑	❑	❑	_____
❑ Grass	❑	❑	❑	_____
❑ Mold	❑	❑	❑	_____
❑ Pollen	❑	❑	❑	_____
❑ Other_____	❑	❑	❑	_____
_____	❑	❑	❑	_____
_____	❑	❑	❑	_____

What first aid is usually administered? ❑ Benadryl ❑ Epipen ❑ Other_____

Will participant carry the above medication to the program daily? ❑ Yes ❑ No

Can participant identify when to use the medication? ❑ Yes ❑ No

Can participant self administer the medication if necessary? ❑ Yes ❑ No

The location of participant's medication is _____

State law prevents City staff from administering or assisting in the administration of medication. Administration of medication is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian. If the participant can administer the medication without assist or reminders, they will be allowed to do so. If not, arrangements must be made with program staff to have someone come to the program to administer the medication.

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ **Signature** _____ **Print Full Name** _____ **Date** _____

FORMULARIO DE INFORMACION SOBRE LAS ALERGIAS DEL PARTICIPANTE

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participante _____

Fecha _____

La información de inscripción del participante aquí nombrado indica que el participante tiene una alergia a _____. Agradeceríamos su cooperación en contestar las siguientes preguntas para mejor comprender di existe alguna necesidad medica.

Por favor enumere las alergias del participante, al intensidad de la reacción alérgica y describe los síntomas. Es la responsabilidad del participante o, para menores de edad y adultos dependientes la del padre custodio o tutor legal revelar toda la información pertinente con respecto a la salud y necesidades especiales del participante.

Allergy	Mild	Moderate	Severe	Symptoms
❑ Picaduras de Abeja	❑	❑	❑	_____
❑ Alimientos	❑	❑	❑	_____
❑ Nueces	❑	❑	❑	_____
❑ Pescado	❑	❑	❑	_____
❑ Otros _____	❑	❑	❑	_____
❑ Polvo	❑	❑	❑	_____
❑ Pasto	❑	❑	❑	_____
❑ Moho	❑	❑	❑	_____
❑ Polen	❑	❑	❑	_____
❑ Otors_____	❑	❑	❑	_____
_____	❑	❑	❑	_____
_____	❑	❑	❑	_____

Cuáles son los Primeros Auxilios que generalmente se administran? ❑ Benadryl ❑ Epipen ❑ Otors_____

El participante llevara el medicamento consigo diariamente al programa? ❑ Yes ❑ No

El participante sabe identificar cuando debe utilizar el medicamento? ❑ Yes ❑ No

El participante puede auto-administrarse si en necesario? ❑ Yes ❑ No

Donde guarda el medicamento _____

Las leyes estatales prohíben que el personal de la Ciudad administre o asista en la administración de **medicamentos. La administración de los medicamentos es la responsabilidad del participante, o para menores de** edad o adultos dependientes, la del padre custodio o tutor legal. Si el Participante puede administrarse el medicamento sin asistencia o recordarios, se le permitiría hacerlo. De no ser así, se administrar el medicamento.

Firma del participante o, para menores de edad y adultos dependientes, la del padre custodio o tutor legal:

✓ **Firma** _____ **Nombre Completo (letra de molde)** _____

PARTICIPANT ASTHMA INFORMATION FORM

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participant _____

Date _____

The registration information submitted for the above participant indicated the participant has asthma. We would appreciate your cooperation in answering the following questions to better understand if there are any medical needs. It is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian to disclose all relevant information regarding the participant's health and special needs.

Please check all known asthma triggers that apply and the severity of the asthmatic reaction.

Trigger	Severity of Reaction
❑ Cold Air	❑ Mild ❑ Moderate ❑ Severe
❑ Dust	❑ Mild ❑ Moderate ❑ Severe
❑ Exercise	❑ Mild ❑ Moderate ❑ Severe
❑ Foods – list:	❑ Mild ❑ Moderate ❑ Severe
❑ Grass	❑ Mild ❑ Moderate ❑ Severe
❑ Mold	❑ Mild ❑ Moderate ❑ Severe
❑ Pollen	❑ Mild ❑ Moderate ❑ Severe
❑ Other – list:	❑ Mild ❑ Moderate ❑ Severe
	❑ Mild ❑ Moderate ❑ Severe
	❑ Mild ❑ Moderate ❑ Severe

What first aid is usually administered?

- ❑ Inhaler
- ❑ Nebulizer treatment
- ❑ Peak flow meter
- ❑ Other _____

Will participant carry the above medication to the program daily? ❑ Yes ❑ No

Can participant identify when to use the medication? ❑ Yes ❑ No

Can participant self administer the medication if necessary? ❑ Yes ❑ No

The location of participant's medication is _____

State law prevents City staff from administering or assisting in the administration of medication. Administration of medication is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian. If the participant can administer the medication without assist or reminders, they will be allowed to do so. If not, arrangements must be made with program staff to have someone come to the program to administer the medication.

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ **Signature** _____ **Print Full Name** _____ **Date** _____

FORMULARIO DE INFORMACION SOBRE EL ASMA DEL PARTICIPNTE

CITY OF SANTA BARBARA
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Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participante _____

Fecha _____

La información de inscripción del participante aquí nombrado indica que el participante tiene asma. Agradeceríamos su cooperación en contestar las siguientes preguntas para mejor comprender si existe alguna necesidad médica. Es la responsabilidad del participante o, para menores de edad y adultos dependientes la del padre custodio o tutor legal, revelar toda la información pertinente con respecto a la salud y necesidades especiales del participante.

Por favor indique todos los factores desencadenantes conocidos del asma del participante y la gravedad de su reacción asmática.

Trigger	Severity of Reaction
❑ Aire Frio	❑ Leve ❑ Moderada ❑ Grave
❑ Polvo	❑ Leve ❑ Moderada ❑ Grave
❑ Ejercicio	❑ Leve ❑ Moderada ❑ Grave
❑ Alimentos-enumerar:	❑ Leve ❑ Moderada ❑ Grave
❑ Pasto	❑ Leve ❑ Moderada ❑ Grave
❑ Moho	❑ Leve ❑ Moderada ❑ Grave
❑ Polen	❑ Leve ❑ Moderada ❑ Grave
❑ Otros- enumerar	❑ Leve ❑ Moderada ❑ Grave
	❑ Leve ❑ Moderada ❑ Grave
	❑ Leve ❑ Moderada ❑ Grave

Cuáles son los primeros auxilios que generalmente se administran?

- ❑ Inhalador
- ❑ Tratamiento de nebulizador
- ❑ Medido de la capacidad pulmonar máxima (peak flow meter)
- ❑ Otro _____

El participante llevara el medicamento consigo diariamente al programa? ❑ Si ❑ No

El participante sabe identificar cuando debe utiliza el medicamento? ❑ Si ❑ No

El participante puede auto-administrarse si es necesario? ❑ Si ❑ No

Donde gurda el medicamneto? _____

Las leyes estatales prohíben que el personal de la Ciudad administre o asista en la administración de **medicamentos. La administración de los medicamentos es la responsabilidad del participante, o para menores de** edad o adultos dependientes, la del padre custodio o tutor legal. Si el Participante puede administrarse el medicamento sin asistencia o recordarios, se le permitiría hacerlo. De no ser así, se administrar el medicamento.

Firma del participante o, para menores de edad y adultos dependientes, la del padre custodio o tutor legal:

✓ **Firma** _____ **Nombre Completo (letra de molde)** _____

PARTICIPANT SEIZURE INFORMATION FORM

CITY OF SANTA BARBARA Parks & Recreation *Enriching People's Lives*

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421

Participant _____ Date_____

Neurologist\Physician _____ Phone_____

The registration information submitted for the above participant indicated the participant has seizures. We would appreciate your cooperation in answering the following questions to better understand if there are any medical needs. It is the responsibility of the participant or, for minors and dependent adults, their custodial parent or legal guardian to disclose all relevant information regarding the participant's health and special needs.

Participant Seizure History	Date	Comments
Date of first seizure	/ /	
Date of most recent seizure	/ /	
Diagnosis and date	/ /	
Length of seizures		
Frequency of seizures		

	Yes	No	
Has had Status Epilepticus	❑	❑	
Has required emergency care for seizures.	❑	❑	
Has had an EEG. Describe test results.	❑	❑	
Has had an MRI. Describe test results.	❑	❑	
Does anything trigger a seizure?	❑	❑	
Has an aura.	❑	❑	
Periods of increased seizure activity.	❑	❑	
Likes to swim.	❑	❑	
Generalized Tonic-Clonic	❑	❑	
Aura or cry	❑	❑	
Loss of consciousness	❑	❑	
Stiffening	❑	❑	
Limbs jerking	❑	❑	
Irregular breathing	❑	❑	
Loss or bladder/bowel control	❑	❑	
Other	❑	❑	
Partial Epileptic Seizure	❑	❑	
Mental Confusion	❑	❑	
Aimless movements: chewing, walking, mumbling, picking at clothes, etc.	❑	❑	
Other	❑	❑	
Non-Convulsive Seizure	❑	❑	
Brief staring	❑	❑	
Tuning out	❑	❑	
Tic like movement	❑	❑	
Head movement or dropping	❑	❑	
Other	❑	❑	

Medication Name	Dosage	Times	Comments

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ **Signature** _____ **Print Full Name** _____ **Date** _____

FORMULARIO DE INFORMACIÓN SOBRE LAS CONVULSIONES DEL PARTICIPANTE

CITY OF SANTA BARBARA Parks & Recreation *Enriching People's Lives*

Parks & Recreation Department
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Participante_____Fecha_____

Neurólogo \ Médico_____TEL_____

La información de inscripción del participante aquí nombrado indica que el participante tiene convulsiones. Agradeceríamos su cooperación en contestar las siguientes preguntas para mejor comprender si existe alguna necesidad médica. Es la responsabilidad del participante o, para menores de edad y adultos dependientes la del padre custodio o tutor legal, revelar toda la información pertinente con respecto a la salud y necesidades especiales del participante.

Antecedentes de Convulsiones	Fecha	Comentarios
Fecha de la primera convulsión	/ /	
Fecha de la más reciente convulsión	/ /	
Diagnóstico y fecha	/ /	
Duración de las convulsiones		
Frecuencia de las convulsiones		

	Sí	No	Comentarios
¿Ha estado en Estado Epiléptico?	☐	☐	
¿Ha necesitado atención de emergencia por sus convulsiones?	☐	☐	
¿Se le ha hecho un electroencefalograma (*EEG*)? Describa los resultados.	☐	☐	
¿Se le ha hecho un *MRI* (estudio del tubo)? Describa los resultados.	☐	☐	
¿Algo desencadena la convulsión?	☐	☐	
¿Experimenta un aura?	☐	☐	
¿Periodos de mayor actividad convulsiva?	☐	☐	
¿Le gusta nadar?	☐	☐	
Tónico-Clónica Generalizada	☐	☐	
Aura o grito	☐	☐	
Pérdida de conocimiento	☐	☐	
Rigidez	☐	☐	
Extremidades se sacuden	☐	☐	
Respiración irregular	☐	☐	
Pérdida de control de vejiga/intestino	☐	☐	
Otro	☐	☐	
Convulsión Parcial Epiléptica	☐	☐	
Confusión Mental	☐	☐	
Movimientos sin propósito: masticar, caminar, hablar entre dientes, jalarse la ropa, etc.	☐	☐	
Otro	☐	☐	
Status No Convulsivo	☐	☐	
Mirada fija por corto tiempo	☐	☐	
Dejar de prestar atención	☐	☐	
Movimientos como tics	☐	☐	
Mover o dejar caer la cabeza	☐	☐	
Otro	☐	☐	

Nombre del Medicamento	Dosis	Horario	Comentarios

Firma del participante o, para menores de edad y adultos dependientes, la del padre custodio o tutor legal:

✓Firma _____ **Nombre Completo (letra de molde)** _____ **Fecha** _____

PARTICIPANT DIABETES INFORMATION FORM

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participant _____

Date _____

The registration information submitted for the above participant indicated the participant has diabetes and is **independent** with their care. Please answer the following questions so we may better understand the participant's medical needs.

CONDITIONS, SYMPTOMS & TRIGGERS

Type of Diabetes ❑ Type I ❑ Type II Age diagnosed _____

BLOOD GLUCOSE TESTING

Is participant aware of when their blood sugar is too low or high ❑ Yes ❑ No

Can participant correctly test their blood glucose levels ❑ Yes ❑ No

Exceptions _____

_____

DIABETES MANAGEMENT PLAN

Additional snacks are needed: ❑ Before exercise ❑ After exercise

❑ Other times (specify)_____

Preferred snack foods _____

Foods to avoid, if any_____

Instructions for when food is provided to all participants_____

Is the participant able to fully monitor and manage their diet requirements? ❑ Yes ❑ No

Exceptions_____

_____

How is the participant's insulin administered? ❑ Injections ❑ Pump ❑ Inhaler ❑ Oral ❑ Other

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

Signature _____ **Print Full Name** _____ **Date** _____

FORMULARIO DE INFORMACIÓN SOBRE LA DIABETES DEL PARTICIPANTE

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

Participante _____

Fecha _____

La información de inscripción que recibimos del participante anteriormente nombrado indica que el/la participante tiene diabetes y es **independiente en cuanto a su cuidado**. Por favor conteste las siguientes preguntas para que entendamos mejor las necesidades médicas del participante.

CONDICIONES, SINTOMAS Y CAUSAS

Tipo de Diabetes ❑ Tipo I ❑ Tipo II Edad a la que se le diagnosticó _____

PRUEBAS DE GLUCOSA EN LA SANGRE

¿El participante sabe cuando tiene demasiado bajo o alto el nivel de azúcar en la sangre? ❑ Sí ❑ No

¿El participante puede medirse correctamente el nivel de glucosa en la sangre? ❑Sí ❑No

Excepciones _____

_____

PLAN DE CONTROL DE LA DIABETES

Necesita un bocadillo adicional: ❑ Antes de hacer ejercicio ❑ Después de hacer ejercicio
❑ En otro momento (especifique) _____

Bocadillos preferidos _____

Comidas que debe evitar, sí las hay_____

Instrucciones para cuando se les proporcionen alimentos a todos los participantes_____

¿El participante puede medir y controlar completamente sus requisitos alimenticios?❑ Sí ❑ No

Excepciones _____

_____

CONSUMO DE INSULINA

¿Cómo se le suministra la insulina al participante? ❑ Inyecciones ❑ Bomba ❑ Inhalador ❑ Oral ❑ Otro

Firma del participante o, para menores de edad y adultos dependientes, la del padre custodio o tutor legal:

✓ **Firma** _____ **Nombre Completo (letra de molde)** _____ **Fecha** _____

AUTHORIZATION FOR RELEASE OF MEDICAL AND PSYCHIATRIC PATIENT RECORDS AND INFORMATION

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

PARTICIPANT (PATIENT) NAME _____ Date of Birth _____

Social Security Number (optional) _____

I, the undersigned, hereby authorize:

Physician or medical facility name _____

Name of participant's school district if participant is a minor _____

to release records and information developed in the course of the diagnosis and treatment of the patient listed above, including medical and psychiatric records, to the City of Santa Barbara Parks and Recreation Department.

This disclosure of medical records and/or information is for the purpose of evaluating the patient's participation in recreation programing offered by the City of Santa Barbara Parks and Recreation Department and to determine what conditions, restrictions or accommodations, if any, are warranted for the patient's participation.

This release shall become valid immediately and shall remain in effect for the length of the patient's participation in the recreation program.

A copy of this authorization shall be as valid as the original. The undersigned has a right to receive a copy of this authorization if a copy is requested.

Signature of participant OR, for minors and dependent adults, the custodial parent or legal guardian:

✓ **Signature** _____ **Print Full Name** _____ **Date** _____

AUTORIZACIÓN PARA LA LIBERACIÓN DE LOS EXPEDIENTES E INFORMACIÓN MÉDICA Y PSIQUIÁTRICA DEL PACIENTE

CITY OF SANTA BARBARA
Parks & Recreation
Enriching People's Lives

Parks & Recreation Department
Adapted Programs
620 Laguna Street
Santa Barbara, CA 93101
(805) 564-5421
www.sbparksandrecreation.com

NOMBRE DEL PARTICIPANTE (PACIENTE) _____

Fecha de Nacimiento _____

Número de Seguro Social (opcional) _____

Yo, el que suscribe, autorizo por medio de la presente:

Nombre del Médico o Clínica_____

Nombre del distrito escolar, si el participante es menor de edad _____

que se liberen los expedientes y la información desarrollados en el transcurso del diagnostico y tratamiento del paciente anteriormente nombrado, incluyendo los expedientes médicos y psiquiátricos, al Departamento de Parques y Recreación de la Ciudad de Santa Barbara.

Esta revelación de expedientes y/o información médica se utilizará para evaluar la participación del paciente en la programación recreativa del Departamento de Parques y Recreación de la Ciudad de Santa Barbara y para determinar las condiciones, restricciones o adaptaciones necesarias, si es que alguna se justifique, para la participación del paciente.

Esta liberación tomará efecto de inmediato y permanecerá en efecto durante el tiempo que el paciente participe en el programa de recreación.

Una copia de esta autorización tendrá la misma validez que la original. El suscrito tiene derecho de recibir una copia de esta autorización si solicita una copia.

Firma del participante o, para menores de edad y adultos dependientes, la del padre custodio o tutor legal:

✓ **Firma** _____ **Nombre Completo (letra de molde)** _____ **Fecha** _____

CITY OF SANTA BARBARA
Parks&Recreation
Enriching People's Lives

PHYSICIAN REPORT AND CLEARANCE
Aquacamp

The participant's physician completes this form. Return it to: City of Santa Barbara Parks and Recreation Department, Adapted Programs, P.O. Box 1990, Santa Barbara, CA 93102. No faxes accepted. For information, call (805) 564-5421.

Participant Name _____ Date of Birth _____ SSN (optional) _____

PARTICIPANT'S HEALTH HISTORY
Please check all that apply and describe condition.

- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Asthma
- ❑ Back Injury
- ❑ Cerebral Palsy
- ❑ Communicable Disease
- ❑ Diabetes
- ❑ Expelling of water difficulty
- ❑ Fainting/Unconsciousness
- ❑ Head/Brain Injury
- ❑ Hearing Loss/Impairment
- ❑ Heart Disease/Defect
- ❑ Incontinence
- ❑ Infection, Injury, Sores, Open Wounds
- ❑ Multiple Sclerosis
- ❑ Orthopedic Injury
- ❑ Respiratory Difficulty
- ❑ Seizure Disorder
- ❑ Stroke/ Neurological Injury
- ❑ Surgery
- ❑ Vision Impairment
- ❑ Wheelchair user

Explanation/other conditions _____

_____

Medications taken by participant _____

Allergies to medication _____

DESCRIPTION OF PROGRAM ACTIVITIES

This program involves travel to local and regional locations and activities that provide a fun, educational aquatic experience. A swim assessment is conducted to ensure when traveling to beaches, aquatic parks and local swimming pools that participants are assigned appropriate restrictions based on swim level. All aquatic environments are supervised by local or City provided certified lifeguards. Activities include swimming (in the ocean, at aquatic parks and local swimming pools where the water depth is 10 feet at the deepest end), sitting or walking for 10-30 minutes, sitting for lessons (on the ground), walking in shallow water, running during games (grass and sand), being outdoors on sunny days, use of scissors, paints, and other equipment for crafts, fishing from pier.

RESTRICTIONS, CONDITIONS AND ACCOMMODATIONS - Based on the program activities listed above and what you know about this participant's medical conditions, what restrictions, conditions or accommodations, if any, should be made with respect to this participant's participation in the program activities? Please be activity specific with your recommendations.

- ❑ May participate with no restrictions or conditions
- ❑ May participate with the following restrictions, conditions or modifications _____

_____

- ❑ Should not participate in any of the program activities listed above
- ❑ Should not participate in the following activities _____

_____

Other physicians or caregivers with whom the Parks and Recreation Department should consult before making a decision concerning this participant's participation _____

PHYSICIAN INFORMATION

Name (print) _____ Phone _____

Address _____ City _____ Zip _____

Signature _____ Date _____